DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 9

2. STATE: NEW MEXICO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 15, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.272

7. FEDERAL BUDGET IMPACT: 7,133,304
a. FFY 2000 $ -0~~2,729,002.00*~~
b. FFY 2001 $ ~~10,215,460.00*~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
pages 20 through 21E

Attachment 4.19-A, Pages 20 - 20A
Attachment 4.19-A, Pages 21 - 21D
Attachment 4.19-A, Page 21E

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: 7,539,004
Attachment 4.19-A, Pages 20 and 20A contain the new language in section #7

Same, TN-99-02
Same, TN-98-98-08
New Page

10. SUBJECT OF AMENDMENT:
Qualified State Teaching Hospitals rate adjustment

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Medicaid Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Robert T. Maruca

14. TITLE: Director, Medical Assistance Division

15. DATE SUBMITTED: September 11, 2000

16. RETURN TO:
Robert T. Maruca, Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09-20-00

18. DATE APPROVED: October 27, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: September 15, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS: *Pen and Ink Change to the Block 7 - Per State's Letter of September 28, 2000.

FORM HCFA-179 (07-92)

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SUPERSEDES: TN - 94-02

quarter.

d. For each subsequent plan year, the sole community hospital is required to submit to the Department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to 30 day extension. Such requests must be received prior to the January 15 deadline.

e. The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.

f. For years subsequent to the initial payment year, the sole community hospital payment adjustment will be the lessor of the amount paid by the Department for the previous year trended forward. The Department will use the market basket forecast published periodically in the HCFA Regional Medical Services letter, or an amount mutually agreed upon by the hospital and the county government.

g. The Department will calculate the Medicare payment limit (specified at 42 CFR 447) annually. If the upper limit has not been exceeded, additional payments will be distributed by the Department. Should the amounts requested from the hospitals exceed the amount available under the upper limit, the amounts will be prorated and distributed based on the amount of the request received by the Department.

7. State Operated Teaching Hospital Adjustment

Teaching hospitals (as defined in section 4.19-A.III.F.8.a operated by

pen & ink change
per State's request

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the State of New Mexico or an agency thereof, shall qualify for an inpatient State Operated Teaching Hospital rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit (specified at 42 CFR 447.272). The Department will calculate the Medicare upper payment limit for State Operated Teaching Hospitals annually. If the upper payment limit has not been exceeded, additional payments will be distributed by the Department to the State Operated Teaching Hospital. The adjustment shall be calculated as follows

a. Each federal fiscal year, the Department shall determine each State Operated Teaching Hospital's Medicare per discharge rate and Medicaid per discharge rate. The Medicare and/or Medicaid discharge rate will be adjusted to reflect any acuity differences that exist between the Medicare and Medicaid patients served. Acuity differences will be determined from the Medicare and Medicaid case-mix indices (CMI) for Medicaid discharges at the hospital using Medicare and Medicaid DRG weights in effect at the time (using data from the most recent state fiscal year for which complete data is available).

b. The Medicaid per discharge rate shall be subtracted from the Medicare per discharge rate.

c. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent state fiscal year. The result shall be the amount of the State Operated Teaching Hospital Adjustment for the current federal fiscal year.

d. For federal fiscal year 2000, and subsequent federal fiscal years, payment shall be made on an annual basis before the end of the federal fiscal year.

e. In the event that the State Operated Teaching Adjustment amount exceeds the Medicare-related upper payment limit for that year, the State Operated Teaching Hospital adjustment will be revised by the difference.

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SUPERSEDES: TN 98-08

8. Indirect Medical Education (IME) Adjustment

Effective August 1, 1992, acute care hospital that qualify as teaching hospital will receive an indirect medical education (IME) payment adjustment, which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

a. In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

1) Be licensed by the State of New Mexico; and

2) Be reimbursed on a DRG basis under the plan; and

3) Have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

b. Determination of a hospital's eligibility for an IME adjustment will be done annually by the state, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualifications were met.

c. The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$$1.89*((1+R)^{.405}-1)$$

Where R equals the number of approved full-time equivalent residents divided by the number of available beds (excluding nursery and neonatal bassinets). Full-time equivalent residents are counted in accordance with 42 CFR 412.105(f). For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for Medicaid managed care enrollees

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if those persons had not been enrolled in managed care.

d. Quarterly IME payments will be made to qualifying hospital at the end of each quarter. Prior to the end of each quarter, the provider will submit to the Department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the Medicaid DRG amount. After review and adjustment, if necessary, the audit agent will notify the Department of the amount due to/from the provider for the applicable quarter. Final settlement of the IME adjustment amount will be made through the cost report. That is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

9. Payment for Direct Graduate Medical Education (GME)

Effective for services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments.

a. To be counted for Medicaid reimbursement, a resident must be participating in an approved residency program, as defined by Medicare in 42 CFR 413.86. With regards to categorizing residents, as described in paragraph b of this section, the manner of counting and weighting resident FTEs will be the same as is used by Medicare in 42 CFR 413.86.

Resident FTEs whose costs will be reimbursed by the Department as a medical expense to a Federally Qualified Health Center are not eligible for reimbursement under this section.

To qualify for Medicaid GME payments, a hospital must be licensed by the State of New Mexico, be currently enrolled as a

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Medicaid provider, and must have achieved a Medicaid inpatient utilization rate of 5% or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the Medicaid inpatient utilization rate will be calculated as the ratio of New Mexico Medicaid eligible days, including inpatient days paid under Medicaid managed care arrangements, to total inpatient hospital days.

b. Approved resident FTEs are categorized as follows for Medicaid GME payment:

1) Primary Care/Obstetrics Resident. Primary care is defined per 42 CFR 413.86(b).

2) Rural Health Resident. A resident participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a Rural Health resident.

3) Other approved resident. Any resident not meeting the criteria for categories 1 or 2, above.

c. Medicaid GME Payment Amount per Resident FTE

1) The annual Medicaid payment amount per Resident FTE for state fiscal year 1999 is as follows:

Primary Care/Obstetrics Resident:	$22,000
Rural Health Resident:	$25,000
Other Resident:	$21,000

2) The per resident amounts specified in paragraph 9.c.1 will be inflated for state fiscal years beginning on or after July 1, 1999 using the annual inflation update factor described in paragraph 9.d.

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d. Annual Inflation Update Factor

Effective for state fiscal years 2000 and beyond, the Department will update the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the HCFA Dallas Regional Medical Services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

The Department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. For example, the Department will use the forecast shown for July 1, 1999 - June 30, 2000 to update the rates for state fiscal year 2000.

e. Annual Upper Limits on GME Payments

1) Total annual Medicaid GME payments will be limited to $5,800,000 for state fiscal year 1999. This amount will be updated for inflation, beginning with state fiscal year 2000, in accordance with paragraph 9.d.

2) Total annual GME payments for residents in Category b.3, "Other," will be limited to the following percentages of the $5,800,000 total annual limit (as updated for inflation in accordance with paragraph 9.d).

State fiscal year 1999	58.3%
State fiscal year 2000	56.8%
State fiscal year 2001	53.3%
State fiscal year 2002	50.7%
State fiscal year 2003	48.0%
State fiscal year 2004	45.5%
State fiscal year 2005	43.0%
State fiscal year 2006	40.4%

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f. Reporting and Payment Schedule

1) Hospitals will count the number of residents working according to the specification in this section during each fiscal year (July 1 through June 30) and will report this information to the Department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12 month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99.

The Department may require hospitals to provide documentation necessary to support the summary counts provided.

2) The Department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in paragraph d, the amount payable to each will be proportionately reduced.

3) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the Department on or about the start of each prospective payment quarter.

4) Should a facility not report timely with the accurate resident information as required in paragraph 1, above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in paragraph e, after prospective payment amounts to timely filing facilities have been established.

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IV. DISPROPORTIONATE SHARE HOSPITALS

To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

B. Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment

Determination of each hospital's eligibility for a disproportionate share payment for the Medicaid inpatient utilization rate as listed below, will be done annually by the department's audit agent, based on the hospital's most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the Department by March 31 of each year.

SUPERSEDES: TN Newage